Policy Guidance

Development of Community Based Crisis Stabilization Services

March 11, 2005

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Foreword on Recovery and Community Based Crisis Stabilization Services

First, When I speak of "being in recovery" I mean that I have a strong, positive sense of identity that is separate from my mental illness diagnoses, my past addictions, my "symptoms," my "condition," and even my behavioral history. I also mean that I have a rich, meaningful and satisfying life despite the obvious human fact that I continue to struggle with Life. Note that I don't dispute diagnostic assertions about my brain bio-chemistry, nor do I fancy myself cured, nor do I make light of my struggles; rather I embrace my brain bio-chemistry and my struggles as a part of living, and I assert my wellness through the choices I make each day in response to what Life presents me. …

Second, when I speak of "crises" I mean much more than the definition provided in the policy guidance. I have come to see them as painfully intensive learning opportunities. As much as I've always wanted to avoid such times, I recognize now that even when it seemed that things were spiraling out of control, I was really being presented with critical lessons to learn—if only I could have looked at what was happening. Even during times when I thought I was at the end of my rope because the pain was too much to bear, my experiences were really presenting me with compelling opportunities to grow. Of course, I never could see those opportunities or the lessons until I was on the far side of the "crisis," and then it was usually only with the help of a peer who challenged me discover them. But from the Wellness Worldview I can see that even in my worst moments I still had all my potential and all my power to become whoever I want to be. All I was missing was some help from a peer in finding and using the lens of Wellness to see my power. So, in times of "crisis" I need my supporters to think bigger than "stabilization" and help me focus on what I want to be so that my journey through and out of crisis is a journey to what I want from life—that focus is where I will find my motivation.

Excerpted from and printed with permission from Steve Pocklington.

The Recovery Model is the clinical foundation for all MH/DD/SAS treatment reform efforts in the state of North Carolina. All services, including crisis response services, must be designed and implemented in keeping with the basic tenets of the Recovery Model. To implement this model, its basic tenets must be understood and translated into practice. They include empowered consumers, a natural and community support system, meaningful roles and relationships, the least restrictive and most natural environment, fostering hope in recovery, evidence based best practices and a holistic approach.

Excerpted from an article by Cindy Peters, Ph.D., Foothills Area Authority.

Table of Contents

This page is blank intentionally.

Development of

Community Based Crisis Stabilization Services

PURPOSE

The purpose of this document is to provide policy guidance to area programs/local management entities (LMEs) regarding the establishment of crisis services and the relationship of such crisis services to each LME's responsibility for access/screening/triage/referral.

By clarifying expectations about the provision of crisis services, the Division also addresses the recently increased utilization of state psychiatric hospitals and provides guidance regarding the development of community capacity for the establishment of a system to better meet the needs of people in an LME catchment area. Many of the clients who are currently served by the state hospitals can be served effectively in community based settings without the need for hospitalization. Others, however, will require brief hospital or crisis unit stays. When client crises arise, the LME must have the capability to respond within its provider system. As the system moves to develop or expand that response capability, it must use scarce resources in ways that are clinically effectiveness and economically efficient.

This document begins with the current requirement regarding crisis services included in the DHHS-LME Performance Agreement, Section 4.3 of Attachment II Statewide Requirements, effective July 1, 2004. Each aspect of that requirement is elaborated below. That section states:

> **4.3 Crisis Services**
>
> *The LME shall maintain a 24-hour, seven days a week crisis response service. Crisis response shall include telephone and face to face capability. Crisis phone response shall include triage and referral to appropriate face to face crisis providers and shall be initiated within one hour. Crisis services do not require prior authorization but shall be delivered in compliance with LME policies and procedures. Crisis services shall be designed for prevention, intervention and resolution, not merely triage and transfer, and shall be provided in the least restrictive setting possible, consistent with individual and family need and community safety.*

The Division recognizes the challenge to establish local services in such a way that needed crisis services can be provided by organizations that (1) meet current licensure requirements, (2) utilize billable service definitions, and (3) experience adequate demand for services to ensure stable organizations. Therefore, alternative ways of organizing short-term crisis stabilization services are provided for consideration by LMEs.[1]

[1] Note that while services for children are included, this document focuses primarily on adults and does not go into depth regarding crisis services for children and youth.

CLARIFICATION OF PERFORMANCE AGREEMENT

24/7 Crisis Response Service

> *The LME shall maintain a 24-hour, seven days a week crisis response service. Crisis response shall include telephone and face to face capability. Crisis phone response shall include triage and referral to appropriate face to face crisis providers and shall be initiated within one hour.*

Each LME is responsible for (1) a phone line that is available 24/7 for individuals to access the system and (2) telephonic or face to face screening, triage and referral, both of which are under clinical supervision and with clinical staff on call. Triage determines if the caller's need is emergent, urgent or routine and that determination defines the route and timeliness of response. The following flow chart illustrates the access/screening/triage/referral process for responding to a caller. [2]

These requirements are applicable to both new clients and established clients.[3]

- If the person is new to the system, the screener collects basic demographic, clinical and financial eligibility information and determines the severity of need. As shown in the flow chart, if the person is experiencing an emergency, crisis services are activated within one hour with face to face response within two hours of initial contact.

- If the person is known to the system, the first responder is the client's primary provider (such as Assertive Community Treatment Team or Community Support Team). Most often, the person will contact the provider first. However, if the person contacts the LME, the screener identifies and contacts the client's primary provider for first response, or locates the client's crisis plan[4] and follows the LME's policy on how and where to access crisis services. Clearly, the screener must have timely access to the necessary information about existing clients and about crisis services.

First Responder – Action is taken 24/7 by the primary provider for existing clients to both prevent escalation and intervene in the person's crisis situation. First response would follow the person's crisis plan. It may be as simple as helping the person identify the trigger that precipitated the crisis and/or known actions that help the person regain control of self. It may be arranging transportation for the person to or meeting them at an observation room at the community hospital emergency room or other safe place so an evaluation may be conducted by appropriate MH/SA qualified professionals. It may involve obtaining authorization for the client to be admitted to a detox or psychiatric facility. If the crisis situation exceeds the capability of first responder, the primary provider contacts the LME for formal crisis procedures to ensure the person's safety and well

[2] See appendix B. Access, Screening, Triage and Referral Protocols, Standards and Documentation Requirements, Uniform Portal Design and Staff Qualification Requirements, Version 2.0, for detailed requirements.

[3], These requirements include those persons returning to the community from a state psychiatric hospital or Alcohol and Drug Abuse Treatment Center (ADATC). Usually, they are considered established clients. Follow the admission and discharge rules in 10A 28F .0200 regarding coordinating continuity of care.

[4] Refer to the Division's Person-Centered Planning Guidelines (3/3/05).

being. Organizations that are required to provide "first responder" crisis response on a 24/7/365 basis are described in table 2 below and in the Service Definitions & Standards currently in review by the North Carolina Division of Medical Assistance (DMA).

LME Crisis Management Responsibility – LME clinical staff initiate action for new clients or established clients that the primary provider is not equipped to handle. It may be arranging for transportation for the person to or meeting the person at the observation room at the community hospital emergency room or other safe place where mental health and substance abuse qualified professionals can determine priority need for detoxification versus psychiatric care and initiate appropriate service as outlined below. If necessary, an LME may activate involuntary commitment and arranging transportation to a local or state psychiatric or detoxification facility. An LME may utilize crisis stabilization beds that are reserved for consumers with MR/MI at a variety of facilities across the state.[5]

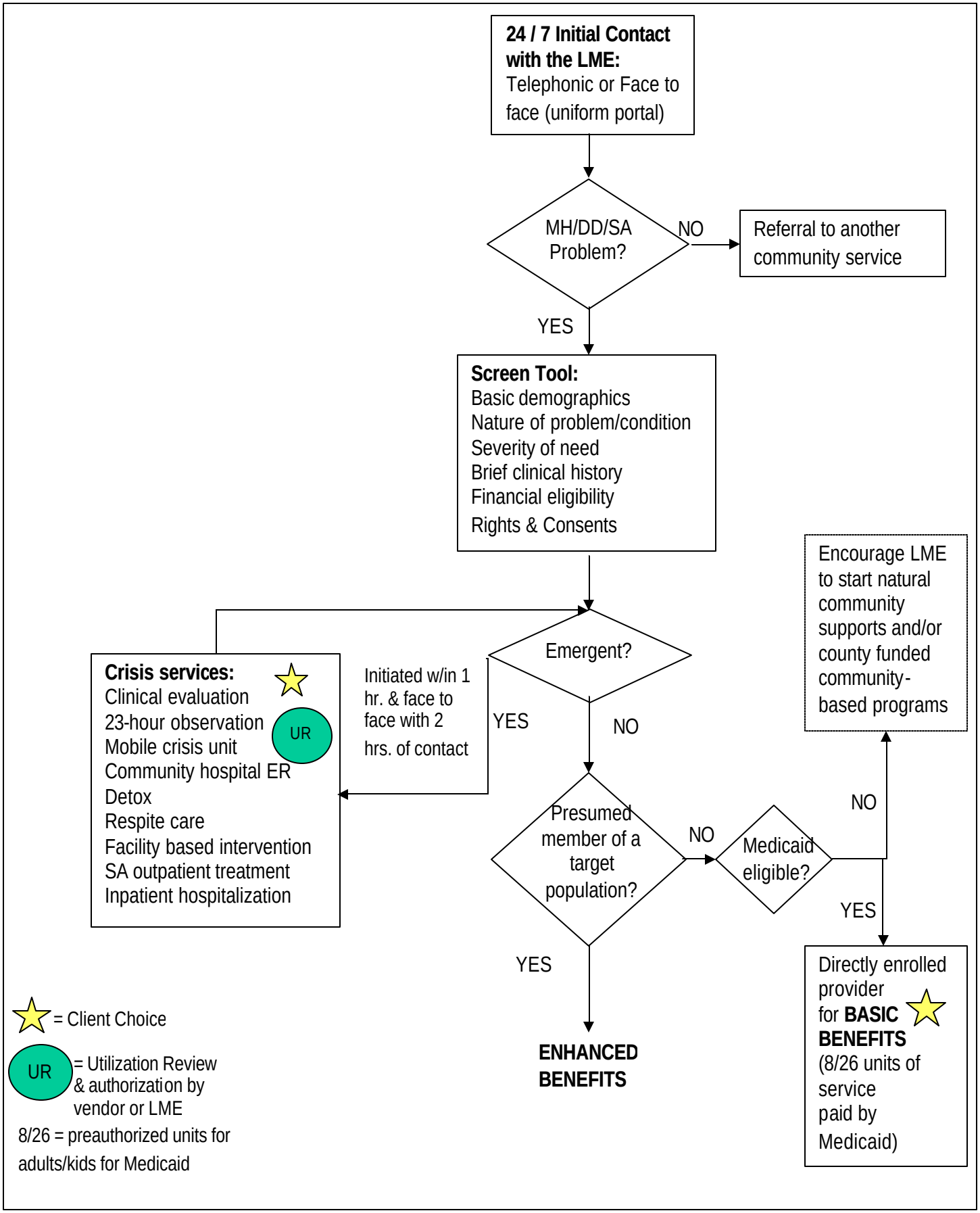
Ultimately, it is the LME's responsibility to ensure that each person in crisis receives appropriate and timely services without regard to how the person entered the system. Consistent with access protocols, there are many avenues of access where a person might enter the system in crisis. For example, table 1 illustrates how different points of contact result in activation of the crisis system.

Table 1. LME Responsibility for Ensuring No Wrong Door

Point of Contact	**New Client**	**Established Client**
LME Access/Screening/ Triage/Referral (including 24-hour crisis line)	MH/DD/SA problem? Nature of problem? Severity of need? Basic demographics Immediate clinical history Financial eligibility Rights & consents Activate emergency services (under clinical supervision)	Nature of problem? Severity of need? Provider of enhanced benefits Crisis plan Provide link to "first responder" or Activate emergency services (under clinical supervision)
Primary Provider as "first responder" (e.g. ACTT, Community Support, etc.)	Contact LME Access/Screening/Triage 24/7 phone line	Nature of problem? Severity of need? Activate crisis intervention per crisis plan
Other crisis stabilization unit or agency (such as local hospital)	Contact LME Access/Screening/Triage 24/7 phone line	Contact LME Access/Screening/Triage 24/7 phone line

[5] The purpose of the funds for diversion beds is to prevent individuals with MR/MI from being admitted to psychiatric hospitals. Funds are spent for training of providers, targeted case managers and specialized crisis staff in including these services in an individual's crisis plan, in building community capacity and for the reserved beds. Currently in the state, LMEs contract with three community hospitals, one locked crisis unit, one unlocked crisis unit, several crisis apartments, alternative family living units, and a home used for MR/MI hospital diversion. The individual's crisis plan would specify the use of a reserved bed.

Access / Screening / Triage / Referral & Crisis Services



Authorization of crisis services

> *Crisis services do not require prior authorization but shall be delivered in compliance with LME policies and procedures.*

In the context of the current performance agreement, this statement refers to an LME's responsibility for a 24-hour, seven days a week crisis response service. The intent is to ensure immediate response to a person in crisis without allowing the need for authorization to delay needed services.

For an established client, utilization management has previously approved the crisis plan as part of the person-centered plan. Authorization of additional services is either the responsibility of the LME or of Medicaid's state vendor. See the specific authorization requirements as stated under utilization management in each of the service definitions.

Authorization is required before a person can be admitted to a state hospital or any inpatient facility.[6] While Medicaid allows 48 hours for an authorization to be obtained for a child or elderly adult admitted to a state hospital, the hospital admission and discharge rules require authorization from the LME within 24 hours. An LME may require a shorter time frame for such authorizations. The LME is ultimately responsible that the authorization is completed.

Crisis service definitions and standards

> *Crisis services shall be designed for prevention, intervention and resolution, not merely triage and transfer,…*

Currently, every person receiving enhanced services must have a crisis plan. The Community Support team who developed the crisis plan with the person is also responsible for monitoring (usually twice a month) and updating the crisis plan. The crisis plan includes identifying the first responder in any crisis event. While Community Support can be used for crisis response as medically necessary, it is the primary provider who knows the client best. Therefore, it is the primary provider who is responsible for first response to the crisis event.

Service definitions and standards that are in review by the North Carolina Division of Medical Assistance (DMA) and the federal Centers for Medicaid and Medicare Services (CMS) are used here to identify those that are applicable to the provision of crisis services. See the most current version of the definitions for accuracy and additional entrance criteria and service limitations.

Tables 2 and 3 present examples of relevant crisis services definitions according to responsibility by first responders or by LME. This is not an exhaustive list.

[6] Follow the admission and discharge rules 10A 28F .0200 regarding admission to an inpatient facility.

Table 2. Examples of "First Response" to crisis using proposed service definitions[7]

Service	Description	Location
Community Support-Adults (MH/SA)	Face to face with the client.	Any location (such as home, school or homeless shelter).
Community Support-Children/ Adolescents (MH/SA)	Face to face with the client.	Any location (such as home, school or homeless shelter).
Intensive In-Home Services	Time-limited intensive family preservation intervention intended to diffuse the current crisis, evaluate its nature, and intervene to reduce the likelihood of a recurrence. Ultimately to stabilize the living arrangement, promote reunification or prevent the utilization of out-of-home therapeutic resources (i.e., psychiatric hospital, therapeutic foster care, and residential treatment facility).	Primarily delivered in the child and family's home.
Multisystemic Therapy (MST)	A program designed to enhance the skills of youth who have antisocial, aggressive/violent behaviors, are at risk of out-of-home placement due to delinquency; are adjudicated youth returning from out-of-home placement; are chronic or violent juvenile offenders, and/or are youth with serious emotional disturbances involved in the juvenile justice system.	Any location.
Community Support Team (CST) (MH/SA)	An intensive community service that provides mental health and substance abuse treatment and restorative interventions and supports necessary to achieve the rehabilitative and recovery goals of the person.	Any location.
Assertive Community Treatment Team (ACTT)	A service provided by an interdisciplinary team that ensures service availability 24 hours a day, 7 days per week and is prepared to carry out a full range of treatment functions wherever and whenever	Any location.

[7] First response may be provided by services not shown here.

Service	Description	Location
	needed. Access to a variety of interventions twenty-four (24) hours, seven days per week by staff that will maintain contact and intervene as one organizational unit.	
Targeted Case Management for Individuals with Developmental Disabilities	A service to assist individuals in gaining access to and monitoring needed services and supports through development of person-centered plan and crisis plan.	Any location.
Substance Abuse Intensive Outpatient Program (SAIOP)	Structured individual and group addiction activities and services provided for recovery and recovery maintenance.	An outpatient program.
Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)	A periodic service, time limited multi-faceted treatment approach emphasizing reduction in use and abuse and/or abstinence, counseling, social network development and various skills for lifestyle change.	An outpatient program.

The LME is responsible for making crisis intervention services available for new clients, for established clients without a primary provider who provides first response, and for recipient clients when the capacity of the first responder has been exceeded. The following are definitions of services that an LME may encourage when building community capacity.

Table 3. Other crisis service definitions for building community capacity

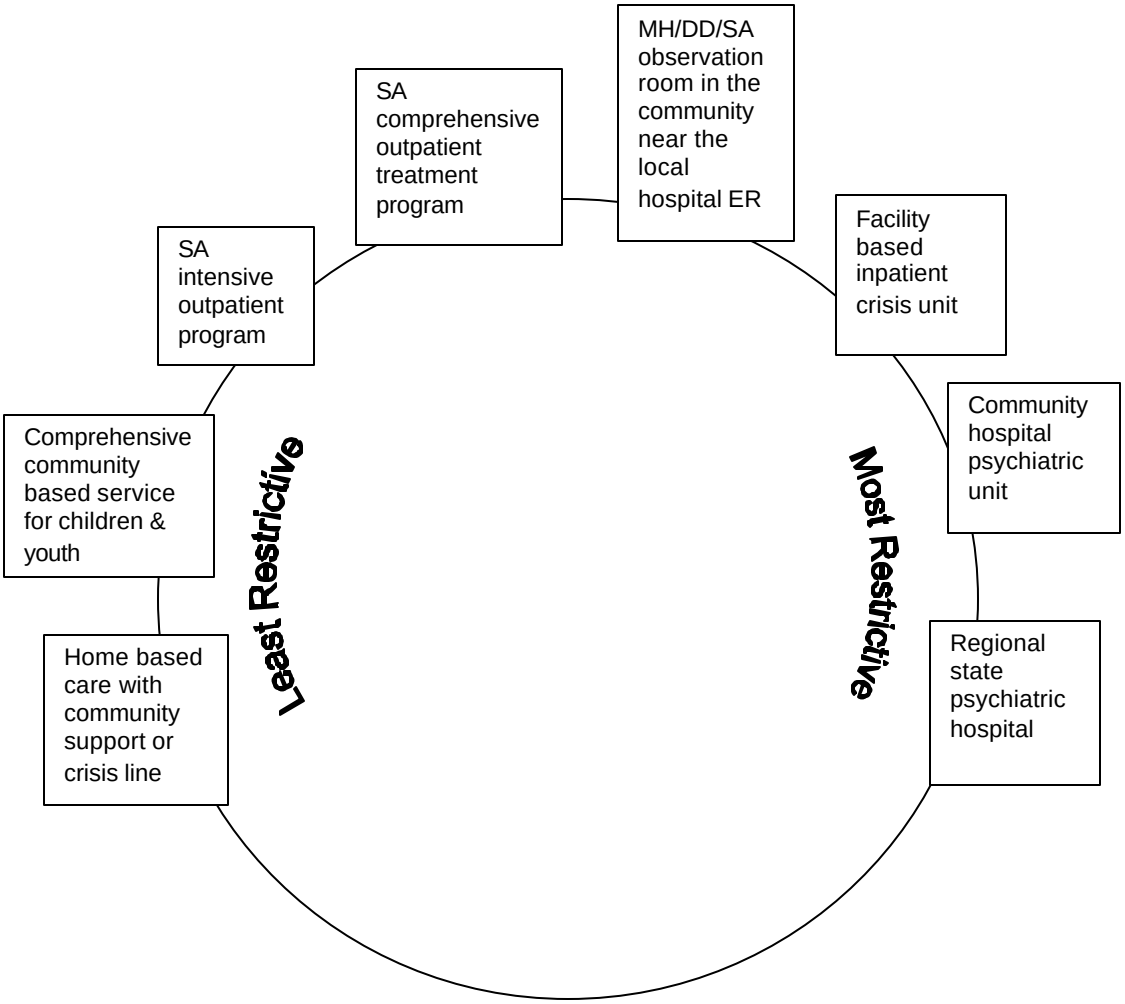
Service	Description	Location
Mobile Crisis Management (MH/SA)	Support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities available 24/7/365.	Face-to-face with the consumer and in locations outside the agency's facility in the least restrictive environment and in or close to a person's home, school, work, local emergency room, etc.
Inpatient Hospital Psychiatric Treatment (MH)	An organized, licensed 24-hour service that provides intensive evaluation and treatment delivered in an acute care inpatient setting by medical and nursing professionals under the supervision of a psychiatrist. This service is	Community hospital psychiatric unit. Also applies to use of the regional state psychiatric hospital through bed day allocation.

Service	Description	Location
	designed to provide continuous treatment for individuals with acute psychiatric problems.	
Facility based Crisis Intervention	An alternative to hospitalization in a 24-hour residential facility that provides support and crisis services in a community setting. Can be provided in a non-hospital setting for recipients in crisis who need short term intensive evaluation, treatment intervention or behavioral management to stabilize acute or crisis situations.	A licensed facility 10 NCAC 14V.5000.
Social Setting Detoxification	A clinically managed residential detoxification program with 24-hour supervision.	At the licensed facility 10A NCAC 14V.3200.
Non-Hospital Medical Detoxification	An organized service with 24-hour medical supervision.	At a licensed facility 10A NCAC 27G.3100.
Medically Supervised or ADATC Detoxification/ Crisis Stabilization	24-hour medically supervised evaluation and withdrawal management providing short term intensive evaluation, treatment intervention or behavioral management to stabilize the acute or crisis situation.	A permanent facility with inpatient beds.

"Least restrictive setting possible"

> *…and shall be provided in the least restrictive setting possible, consistent with individual and family need and community safety*

Crisis services can be delineated as an array of settings from least to most restrictive where home-based care might be the least restrictive and a locked inpatient facility the most restrictive. However, there is not an exact linear relationship among services regarding restriction. A crisis service must be consistent with the person's crisis plan that is based on individual and family need. One person might experience a particular service as too restrictive, while another person may experience the same service as providing needed freedom. Personal and community safety may require the use of a locked facility. Settings may range from least to most restriction as shown in the following diagram.



ALTERNATIVE SHORT-TERM CRISIS SERVICE ARRANGEMENTS

Establishing new service provider organizations or preparing existing organizations for new service definitions and agreements with LMEs and DMA is a challenge. The intent of this section is to suggest ways that new organizations or existing organizations with current facility licenses, physical plants and staff might evolve in the provision of crisis services in preparation for new service definitions and eventual changes in licensure rules.

Having the community capacity to deliver a broad array of services within an LME's catchment area is ideal for responding to the range of possible crises of the people we serve. This may be accomplished with a variety of organizational arrangements and vary significantly across LME catchment areas. For example, what might be economically feasible in a metropolitan area may not work for an LME of a large rural geographic area.

As elaborated in appendix D, the Division encourages the development of contractual relationships between LMEs and local general hospitals as the preferred method for addressing the crisis needs of people with mental health, developmental disabilities and substance abuse disorders. Community members know and readily use the community hospital for emergency services. In addition to access to a thorough and timely assessment of a client's physical and mental state, use of the hospital represents an efficient and effective use of financial resources. Medicaid covers the cost of inpatient care for clients who are Medicaid eligible, whereas it only covers the cost of treatment in crisis stabilization units, leaving the cost of room and board for those clients to be covered by state and local appropriations. See appendix E for the collaboration protocols for North Carolina hospitals and LMEs.

A tiered approach to building local capacity might include the following actions for an LME.

1. Establish a formal relationship between the LME and a community hospital within the catchment area. The contract might specify that the hospital will receive people experiencing mental health or substance abuse crises, notify LME when a person appears for crisis services and provide private space available 24 hours/day for observation of the person by qualified MH/SA staff.[8] The LME will arrange for qualified MH/DD/SA staff to work with the person in crisis until resolution is reached. That resolution may involve observation, evaluation, returning the person to his/her home, admission to another facility, admission to the community hospital or referral to a state facility. The LME is responsible for activating procedures for referral of clients to state inpatient psychiatric hospitals and ADATCs when appropriate.

2. Secure qualified mental health and substance abuse staff to provide 24-hour on call crisis services as LME employees or by contract (perhaps hospital staff).

[8] Ideally this is a separate room or space near the emergency room in the community hospital or a private service within walking distance of the ER that is designated for supervised observation for up to 23 hours. This is a calming, safe space with recliner chairs where staff from one or more MH/DD/SA provider(s) can be available 24/7 to provide immediate support to the person in crisis. Qualified staff can evaluate the person's mental health and/or substance abuse condition and safety over time and make a clinical decision appropriate to the situation, rather than automatically initiating involuntary commitment.

3. Train staff who fulfills the Access/Screening/Triage/Referral function of LME to conduct triage according the LME policy and procedures. See appendix B for access, screening triage and referral protocols, standards and documentation requirements, uniform portal design and staff qualification requirements.[9]

4. Inform local police, public agencies, and LME and provider staffs of the agreement with hospital and LME policies and procedures for handling crises.

5. Establish, reinforce and/or secure training for Assertive Community Treatment Teams (ACTT) and Community Support Teams to work with established clients according to proposed service definitions, including being "first responder" in case of crises.

6. Based on geographic area and population density, LME select most appropriate types of other crisis services and negotiate with existing and potential providers for these services. See table 4. Assist those providers in planning, establishing business, training and initial operations by providing utilization data and information on service definitions and rates, accessing start up funding, direct enrollment with DMA, billing procedures/expectations, training in person-centered and crisis planning, and utilization review and authorization of services. Appendix C provides the benefit package for each service description the billing code, units of service and proposed 7/1/05 rate for services.

7. Implement a data management system that supports the functions of access/screening/triage/referral, crisis services, utilization management, service delivery and coordination, and quality management. This system would enable real time access to information about every client and communication among appropriate LME and provider staffs. Ultimately, the Division anticipates this system would be fully automated.

8. Establish and distribute to providers a monthly crisis report on the incidence and types of crises, disposition and trends to support regular management review and decision-making about the local system of crisis response.

9. Adjust plan for crisis services as needed.

Table 4 lists possible organizational structures for providing short-term crisis stabilization services from which an LME might select a range of service providers. This table takes into account several factors including the size of an LME's geographic area, population density and probable economic base to support services.

- **Metropolitan** – Highest density of people in the smallest geographic area (one county or less) with the greatest incidence of crises (some precipitated by crowding) and a greater economic base to support crisis services. (Examples are the LMEs that contain Mecklenburg, the Triad, the Triangle, Asheville, Wilmington.)

- **Rural** – One LME with moderate density of people in a geographic area equal to one or more counties with a lower incidence of crises and a lower economic base than a metropolitan area to support crisis services. (Includes all other LMEs.)

[9] Co-locating the LME's Access/Screening/Triage/Referral staff and crisis stabilization staff is an optional way to make both services affordable.

- **Sub Regional** – A collaboration of two or more LMEs with moderate density of people in a rural geographic area equal to five or more counties, thereby increasing the total population and demand for crisis services and economic base to support crisis services.

- **Regional** – One of state's MH/DD/SA geographic regions covering 30 or more counties thereby increasing the demand and economic feasibility to spread costs over larger economic base.

Notes:

Home Based Crisis Care: can be provided by Community Support Teams, ACTT, Intensive In-Home or Targeted Case Management.

Wraparound for children/youth: Can be provided by Multisystemic Therapy (MST) provider; Intensive In-home provider or Community Support.

Mobile Crisis Management: An LME may contract with a service provider or hospital to provide this service. It may be linked to law enforcement for cases such as suicide attempts or domestic violence. This service is primarily delivered face to face with the client and in locations outside the agency's facility. It includes crisis prevention and supports designed to reduce the incidence of recurring crises and should be specified in a person's crisis plan. Usually most cost effective in an urban setting, this service is usually delivered by a team of MH/SA professionals. This is a Medicaid second level[10] billable service available 24/7/365 for mental health and substance abuse clients.

Sub Regional Comprehensive Crisis Facility: In this model, two or more LMEs may join to establish or contract with one provider of crisis services to serve an area greater than one catchment area yet smaller than a region to make a provider's organization affordable and viable. Usually, this would involve a continuum of services. Essential to such an arrangement is a document stating clear agreements among the parties involved.

[10] If the person's outpatient clinician or Community Support worker stabilized the crisis, the outpatient or community support billing code should be used, not crisis management.

Table 4. Alternative short-term crisis stabilization services by geographic area, population density and economic base

Metropolitan	Rural	Sub-Regional	Regional
First Responders			
Mobile Crisis Unit			
Assertive Community Treatment Team (ACTT)			
Community Support (MH/SA)	Community Support (MH/SA)		
Intensive In-Home Services	Intensive In-Home Services		
Targeted Case Management (DD)	Targeted Case Management (DD)		
Substance Abuse Intensive Outpatient Program (SAIOP)	Substance Abuse Intensive Outpatient Program (SAIOP)		
Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)	Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)		
Multisystemic Treatment (MST)	Multisystemic Treatment (MST)	Multisystemic Treatment (MST)	
Other Crisis Stabilization Services			
Community Hospital Observation (23-hour "bed")	Community Hospital Observation (23-hour "bed")	Community Hospital Observation (23-hour "bed")	
Crisis unit within Comprehensive MH or SA Provider Organization	Crisis unit within Comprehensive MH or SA Provider Organization	Crisis unit within Comprehensive MH or SA Provider Organization	
Community Hospital Psychiatric Inpatient Unit	Community Hospital Psychiatric Inpatient Unit	Community Hospital Psychiatric Inpatient Unit	
Comprehensive Crisis Center	Comprehensive Crisis Center	Comprehensive Crisis Center	
Detox Services (social setting or non-hospital medical detox)	Detox Services (social setting or non-hospital medical detox)	Detox Services (ambulatory or non-hospital medical detox)	
Medical Detox/Crisis Stabilization	Medical Detox/Crisis Stabilization	Medical Detox/Crisis Stabilization	
			Inpatient Psychiatric Hospital
			Medical Detox/Crisis Stabilization (ADATC)

This page is blank intentionally.

APPENDIX A. DEFINITIONS

ACCESS – Where and how someone makes initial contact with the MH/DD/SA system.

CRISIS – A response to stressful life events that may seriously interfere with a person's ability to manage. A crisis may be emotional, physical, or situational in nature. The crisis is the perception of and response to the situation, not the situation itself.

CRISIS INTERVENTION - Services and supports aimed at helping a person manage a crisis safely and return to his or her regular life.

CRISIS PLAN – A crisis plan is developed as part of the individual's person centered plan. Essential elements include:

1. A proactive component that identifies early known warning signals and triggers of an impending crisis.

2. An intervention component for steps when the individual is experiencing emotional, physical or situational difficulties that interferes with his/her ability to manage immediate needs without assistance.

3. Information about the process or procedure will be followed when a crisis event or emergency situation occurs, such as who to call as First Responder, what actions to take with the individual in crisis, and what crisis services or hospitals should be used.

CRISIS RESPONSE – Immediate response to assess for acute mh/dd/sa service needs, to assist with acute symptom reduction, and to ensure that the person in crisis safely transitions to appropriate crisis stabilization services. These services are available 24 hours per day, 365 days per year.

CRISIS STABILIZATION – Services and supports following crisis response that are intended to assist the person in crisis to return to his/her regular life.

EMERGENCY SERVICES – Services designed to assist individuals in an acute crisis that are, or are likely to become, dangerous to themselves or others. Emergency Rooms of general hospitals are one example. See also, **CRISIS SERVICES.**

EMERGENT – A life-threatening or non life-threatening emergency.

FIRST RESPONDER – A person or personnel of an agency designated as the Primary Provider by the person centered plan (PCP) who will have access to the individual's crisis plan at all times and be knowledgeable of the local crisis response system.

REFERRAL – A procedure by which the screening professional and the consumer choose a clinically appropriate provider and facilitate the consumer's successful contact with that provider so that services can be initiated.

SCREENING – A brief interview designed to first determine if there is there a MH/DD/SA need and if the need emergent, urgent, or routine; and secondly, an initial determination as to whether or not the caller appears to be a member of a target population.

TRIAGE – An initial diagnostic determination resulting in appropriate referral(s) for the consumer.

APPENDIX B. ACCESS, SCREENING, TRIAGE AND REFERRAL PROTOCOLS, STANDARDS AND DOCUMENTATION REQUIREMENTS, UNIFORM PORTAL DESIGN AND STAFF QUALIFICATION REQUIREMENTS, VERSION 2.0

The North Carolina State Plan 2003: Blueprint for Change states that system entry (screening, triage and referral) should assure ease of access organized through the Local Management Entity (LME) in order to respond to community members as quickly and accurately as possible. This includes a brief screening and triage in order to determine if a MH/DD/SA problem exists, to assess the urgency of the situation, and to make an initial determination as to type of problem and target population status so that a referral can be made to an effective service. This follows the Plan's value of a "No Wrong Door" which states that there must be many avenues of access where people can enter the system in a manner that is customer-service oriented in approach and exhibits a genuine desire to help those who enter. The Person Centered planning and thinking process is interwoven throughout the system and begins with the first contact the individual has with the system. The concept of uniform portal, described below, establishes the expectation of a consistent statewide process for entering and leaving the public service system that supports and facilitates access to services no matter where the person enters. Proposed standards for access to services are outlined below and allow the LME and it's providers to respond to people in an appropriate and timely manner. Following the access standards, the elements making up an acceptable screening and triage protocol are presented along with the qualifications of staff performing these functions. The elements necessary to screen individuals seeking services is presented. Thus, the access, screening, triage, and referral process will be standardized and performed according to consistent statewide protocol whose elements are listed below. It is recognized that some LME's will need to build their crisis capacity.

Access

Access is defined as where and how someone makes initial contact with the MH/DD/SA system. Access is determined by the urgency of need assessed. This will be emergent, urgent, or routine. The goal is to resolve the crisis/situation in a proactive and supportive way that engages the consumer, family, or other support persons and ultimately engages the person into services. Access has to be a very responsive system that is focused on "consumer risk reduction" and works to remove burdens or barriers on the consumer or family to get the help that is needed. .

Access Standards

- Emergent response: consumers with life threatening/non life threatening emergency needs will be seen immediately or within two hours after the request for care is initiated or 911 will be called if indicated.
- Urgent response: consumers will be seen within 48 hours.
    - Consumers determined to have an substance abuse need are presumed to require either an Emergent or Urgent response
- Routine response: care must be provided within 7 calendar days. However, consumers will be seen the same day the service is requested if:
    - There is an available appointment that day.
    - The consumer would like to wait for a possible cancellation.

- A uniform portal shall exist whereby the same elements exist for access regardless of where the person enters the system (i.e., walk-in, statewide toll free line, LME, provider).

- The response is immediate in that the telephone is answered in less than six rings or within 30 seconds.
- Consumers will have telephone access to a live person able to respond with the ability to screen and refer 24/7. TTY service will be available for individuals who have deafness or are hard of hearing. Foreign language interpretation capabilities, including sign, will also be available.
- The person initially answering the call will be a staff person qualified to provide screening services.
- The telephone system must have electronic caller identification and call tracing.
- The person initially answering the call must have the ability to get help from staff when needed to manage the call.
- If the person has transportation issues that prevent access, the LME will work with the family, local community, and others to develop resources to address this issue.
- The person initially answering the call is qualified to assess the priority of the call according to written procedures.
- Telephone abandonment rates or overflow to voice mail are not to exceed 5% at any given time.

- Walk-ins to the LME or a service provider:
    - An LME staff person qualified to provide screening will see the consumer within 15 minutes from time of walk in to perform the screening and triage. The screening and triage is to determine the existence of a MH/DD/SA need, determine the urgency of this need, and to triage the need into an emergent, urgent, or routine level.
    - If the consumer presents in person at a service provider and has not been referred by the LME, the provider should contact the LME and allow the person to receive the screening, triage, and referral by the LME over the phone in order to secure authorization to perform further services as indicated.

- Telephonic presentation to the LME or a contracted service provider:
    - If the consumer telephones the LME directly the protocol is the same as when the call comes to the statewide toll free number.
    - If the consumer telephones the service provider directly, the provider should refer the caller to the LME.

- On-line or Web based contact:
    - The staff person receiving this contact will refer the contact to the appropriate LME as soon as possible but not later than one hour after receiving/opening the contact.

- Contact with other local agency:
    - Information will be offered to other agencies to assist in training them to refer requests for MH/DD/SA services to the appropriate LME.
    - The individual will be referred to the LME for screening.
    - There is no wrong door within the MH/DD/SAS system.

- Telephonic presentation to the statewide toll free number:

- There is a statewide toll free number, which will read electronically the caller's area code and telephone prefix and automatically route that call to the appropriate LME. Each LME operates (or may contract for) an access line that is staffed 24/7 with live, qualified staff. These lines receive calls routed from the statewide server and calls made directly to local access line.

- Telephonic presentation to the LME access line:
  - This line is to be live-staffed 24 hours a day 365 days a year.
  - Calls are answered by the sixth ring or 30 seconds whichever is less.
  - Calls are directed to qualified staff who have been trained and credentialed to perform screening, triage, and referral.

- The LME will have or contract for a Crisis Emergency System that may involve several models of crisis response (e.g. on-call staff, mobile crisis team, clinic or facility based crisis screening). All components of the Crisis Emergency System are staffed by clinicians. Telephonic clinical triage of the problem to determine which type of crisis response is required. The following list is not exhaustive.
  - Telephonic crisis intervention counseling, as appropriate.
  - Dispatch mobile crisis team, if exists and as appropriate.
  - Dispatch on-call staff to the emergency room as appropriate
  - Arrange for inpatient assessment and admission, or alternative hospital admissions placements.
  - Liaise with local law enforcement in situations where needed.
  - Maintain Crisis Plans on file for active consumers, including contact information for current case manager or primary clinician in the qualified provider network.
  - 23 hours observation bed
  - emergency respite

Access Staff Qualifications

- Staff credentialed by the LME to perform the access function.

Screening and Triage

Screening involves a brief interview designed to first determine if there is there a MH/DD/SA need and if the need emergent, urgent, or routine. Secondly, screening will offer an initial determination as to whether or not the caller appears to be a member of a target population. Finally, the triage provides an initial diagnostic determination and appropriate referrals for the consumer.

Screening and Triage Standards

- A uniform portal shall exist whereby the same elements exist for screening and triage regardless of where the person enters the system (i.e., walk-in, statewide toll free line, LME, provider). Screening and triage is the responsibility of the LME but this may be contracted and/or connected to a crisis service. If someone enters through any door, they will be referred to the LME screening and triage service and the protocols for that service will be uniform across North Carolina.
- Access, Screening & Triage Staff will offer an initial determination as to whether or not the caller appears to be a member of a target population.

- Access, Screening & Triage Staff will maintain a call log that minimally includes basic identifying information, referral source, type and time of call, assessment of risk and disposition.
- Access, Screening & Triage Staff will gather the demographic information named in the documentation section below using a customer friendly interview format.
- Access, Screening & Triage Staff will document discussion of referral options with the consumer and/or family.
- Access, Screening & Triage Staff will document the referral(s) made.
- One hundred percent of new consumers experience the screening function as a part of a caring and person centered process. Current consumers are not required to under go screening to continue with current service providers, until a new person-centered plan is developed with consumer knowing a range of choices.
- Screening/triage decisions made at local hospitals should be made by Qualified Clinical Professionals assisting the ER in making decisions with an on-call psychiatrist who provides backup.
- Staff must be knowledgeable and able to deal with issues of involuntary commitment and a person's ability or lack thereof to give informed consent.
- Staffing should take into account high volume times and staff accordingly.
- Consumers should not be required to undergo multiple intakes or screenings.
- Consumers need to get to the point of assessment and service as quickly as possible. The goal is to avoid duplications of both the screening and assessment functions.
- Consumers presenting in person must be continually observed until qualified clinical staff sees them.

Screening and Triage Protocol

- All calls to the LME are answered by live, trained credentialed clinician by the sixth ring or 30 seconds whichever is less.
    - Clinician immediately determines if call is emergent, urgent or routine.
    - Caller requesting basic information or referral outside system is referred as needed.
    - Clinician begins to complete the screening template, which is completed with every triage call.
    - Clinician records date and time of call.

- There shall be documentation to demonstrate that an individual who initiates contact for MH/DD/SA services has been screened for the purpose of determining the nature of the individual's problem(s), condition, or need(s) for services and supports.
- Screening/triage forms may be developed and the form may incorporate the call log, screening/triage information, referral and disposition. The template for screening must include the following elements: basic identifying information, referral source, type of call, assessment of risk and disposition. Staff shall gather the following information:
    - Consumer name (first, middle initial, last and maiden)
    - Caller name if other than consumer and relationship to the consumer (first, MI, last)
    - Parent's name or guardian (if applicable)
    - Address (home address as well as location from where the call is placed)
    - Home phone (determine if okay to call or not)
    - Work phone (determine if okay to call or not)
    - Date of birth

- Gender
- Referral source
- Determine whether the consumer is court ordered, court involved, or in custody (if in custody, guardian's name and phone number)
- Determine whether consumer had been seen previously or is open with the LME or a provider.
- Nature of problem and diagnosis, if known
- Case manager (if applicable, including determination of open record with LME or provider)
- Where referred following triage
- Emergency contact information name and phone
- Custody, court ordered, or involved information (if applicable)
- Accommodations for physical, language, or cultural barriers
- Transportation availability to get to referral

- Information gathered in the screening process should be forwarded to the provider receiving the referral.
- Non Clinical Needs – If the call is regarding a non clinical need and no threat exists, the response is treated as routine and care is provided as soon as possible within that standard.
- Emergent Calls - If call is emergent (a caller with a life-threatening or with non-life-threatening emergency):
    - Caller needs to be seen face to face within two hours after the request for care is initiated. The provider will respond within one hour and will meet with the consumer within two hours.
    - Family or friends will be included if requested by the consumer.
    - If indicated the clinician immediately refers the caller to the emergency room or crisis facility of the caller's choice for an emergency evaluation, or to the Magistrate if appropriate.
    - Clinician will also call 911 to request assistance if indicated.
        - referral information is recorded
        - clinical follows up with phone call to referral source
        - follow-up is recorded
    - For persons being evaluated for commitment, relationships with local law enforcement is encouraged to ensure the transportation of individuals to screening locations and to have the officer stay with the consumer during the first level commitment screening.
    - If the individual is assessed as needing admission to a state psychiatric hospital or ADATC, the LME is responsible for ensuring:
        1. The completion of the Regional Referral Form (DMH-1-73-03), including the authorization number, the number of bed days authorized at the time of the evaluation, and the required demographic and clinical components; and
        2. That the Regional Referral Form is faxed to the state institution or accompanies the patient at the time of admission.
    - Efforts should be made to determine if there are advance directives under GS 122C-77.

- Urgent Calls - If the call is determined to be urgent the following apply.
    - Care must be provided within 48 hours.

- The provider network must be organized in a manner that facilitates timely access to services and supports**.** Each LME will be expected to meet the standard of having services available to residents of the catchment area within 30 minutes drive time or 30 miles distance. Exceptions to this standard exist when a community has no medical or mental health resources within the 30 minute or 30 mile benchmark.

- Routine Calls: If the call is determined to be routine, the following apply.
  - Care must be provided within 7 calendar days.
  - Clinician schedules the face to face assessment.
  - Caller is told that if the consumer is in the custody of an adult or legal guardian, the legal guardian/parent/custodian must come with the consumer to the face to face assessment except for persons seeking outpatient SA treatment.
  - Consumer can also call to make his/her own appointment after the referral has been entered for the provider.
  - Access, screening & triage staff completes all documentation according to protocols.

Access, Screening & Triage Staff Qualifications

- Staff performing the screening, triage, and referral service should be qualified professionals with a bachelor's degree and MH/DD/SA training who are credentialed to provide these services and to give a dispositional diagnosis.
- This staff is supervised by an on-site master's level clinician.
- Qualified clinicians must be trained in crisis intervention and other behavioral health emergency techniques.
- Any LME or contracted providers performing triage and screening functions should have staff that include at a minimum:
  - Two clinical access, screening & triage staff
  - A psychiatrist for oversight who is available on-call
  - Rapid access to the on-call clinical staff is necessary when demand is high.
  - A certified substance abuse counselor must be a part of the team.
  - A qualified professional who has experience in developmental disabilities must be a part of the team.

Referral

Referral is the procedure by which the screening professional and the consumer choose a clinically appropriate provider and facilitate the consumer's successful contact with that provider so that services can be initiated. The person-centered philosophy is an integral part of this process as the individual's needs and wishes are the center of the process. Inherent in screening is the function of referral. This is true for those who have no MHDDSA need as well as for those with needs that are appropriate for further assessment. Care coordination from the LME regarding referrals should include a follow up with the provider to ensure that the individual was seen as referred. In situations where there is some safety risk during this transition, it is the responsibility of the LME to take the steps necessary to ensure the safety of the individual. One part of the referral is the authorization of the assessment and initial clinical services that is performed by the LME or its designee.

Referral of Target Populations

- For person's screened to be in the target population, the referral is to a provider who will perform an intake assessment and develop the person-centered plan (PCP) utilizing the enhanced benefits. The screening professional will enter an authorization for these services. If the intake assessment suggests that the person is not in a target population, the provider will contact the LME for a referral to an appropriate level of service.

Referral of Non-Target Populations

For person's screened to not be in the target population but having Medicaid, the referral is to a provider who will evaluate and offer treatment services utilizing the basic benefits. The referral might also be to a community self-help or peer support organization. If a referral is to be to a provider for further assessment and possible treatment, the screening professional will enter the authorization for these services. If the person is screened to be not in the target population and does not have Medicaid, then a referral to natural community supports and/or county funded community-based programs. If the evaluation suggests that the person is a member of a target population, the provider will contact the LME for a referral to an appropriate level of service.

Referral Standards

- The provider network must be organized in a manner that facilitates timely access to services and supports. Each LME will be expected to meet the standard of having services, as designated in rule, available to residents of the catchment area within 30 minutes drive time or 30 miles distance. Exceptions to this standard exist when a community has no medical or mental health resources within the 30 minute or 30 mile benchmark. LMEs are expected to work with their community in advocating for adequate transportation of person's with MH/DD/SA to attend treatment. Exceptions to the standard will be approved by the LME.
- The referral should take into account and make every effort to accommodate consumer choice whenever possible.
- The referral shall be to a provider deemed to be qualified to treat the issues that appear to be present based on the screening.
- The screening clinician shall be able to offer a specific appointment time to the individual.
- The provider must be able to offer first level toxicology screening.
- The authorization should be to a masters level outpatient clinician or to the responsible professional in a treatment team.

Referral Protocols

- The screening clinician must have access to current appointment times with providers of choice.
- Screening unit makes "active linkage" of caller to a service provider; schedules an appointment for an intake assessment. LME Access, Screening & Triage Staff makes a follow-up call with the individual to assess whether linkage occurred.
- Client rights and customer service material will be available on the first visit to the provider.

Referral and Disposition Documentation Requirements

- Screening staff will document discussion of referral options with the consumer and/or family.
- Screening staff will document the referral(s) made.
- Screening staff will sign and date document.
- Document follow-up contact to assure linkage.
- Signature of staff completing follow-up and date.

APPENDIX C. DMH/DD/SAS PROPOSED 2005-06 BENEFIT PACKAGE

Service Description	Billing Code	Unit of Service	Proposed 7/1/05 Rate for Service[11]
Community Support – Individual	H0036	Per 15 minutes	$15.24
Community Support – Group	H0036 HQ	Per 15 minutes	$4.90
Mobile Crisis Management (MH/SA)	H2011	Per 15 minutes	$31.79
Intensive In-Home Services	H2022	Per diem	$190.00
Community Support Team (MH/SA)	H0037	Per 15 minutes	$16.52
Multisystemic Therapy	H2033	Per 15 minutes	$23.54
ACTT	H0040	Event, max 4/month	$323.98
Facility Based Crisis Intervention	YP485		Specific to provider
Inpatient Hospital Psychiatric Treatment	YP820	Bed Day	N/A
Ambulatory detoxification	H0014	Per 15 minutes	$20.43
Non-hospital medical detoxification	H0010	Per diem	$325.88
Medically supervised or ADATC Detox/Crisis Stabilization		Per diem	Per diem rate will be determined by individual provider
Substance Abuse Intensive Outpatient Program	H0015	Per diem	$131.93
SA Comprehensive Outpatient Treatment program	H2035	Per diem	$183.07
Inpatient Hospital Substance Abuse Treatment	YP820	Bed Day	N/A

[11] Final service rates published by the Division and posted on the web site: http://www.dhhs.state.nc.us/mhddsas/

APPENDIX D. POLICY GUIDANCE – DEVELOPMENT OF COMMUNITY BASED INPATIENT OR CRISIS STABILIZATION SERVICES

Central to the public MHDDSAS system's ability to downsize the state run institutions is the availability of local inpatient or other 24/7 crisis stabilization services. All too often, institution admission is precipitated by a community's lack of capacity to respond to clients' crisis or emergency needs. During the past few months there has been a good deal of discussion and interest among area programs/local management entities regarding the development of crisis stabilization units. Conceptually, these units would meet the needs of those clients who are currently being served in the acute care units of the state hospitals. The purpose of this document is to provide policy guidance to area programs/LMEs in the development/expansion of local inpatient or crisis stabilization units. For purposes of this document inpatient service means, a service provided in a hospital setting on a 24-hour basis under the direction of a physician. Crisis stabilization unit means, a service licensed as Residential Acute Crisis Treatment that provides crisis services in a 24-hour residential non-hospital facility.

Current plans call for the elimination of 783 beds in the four state hospitals over a five-year period. Many of the clients who are currently served by these beds can be served effectively in community based settings without the need for hospitalization. Others, however, will require brief hospital or crisis unit stays. When these client crises arise, the LME must have the capability within its provider system. As the system moves to develop or expand that response capability it must use scarce sources in ways that are clinically efficacious and economically efficient.

As a matter of policy, the Division encourages the development of contractual relationships between LMEs and local general hospitals as the preferred method for addressing the crisis needs of people with mental health, developmental disabilities and substance abuse disorders. The local general hospital emergency room is, in most instances, the primary place to which clients in crises are transported - by family members and local law enforcement. In view of this phenomenon the LME should first consider a partnership with its local hospital(s) as plans are made for developing or improving emergency services and providing inpatient/ crisis stabilization services. These contractual relationships can be especially beneficial in those instances where the local hospital also operates an inpatient psychiatric unit. Such an arrangement can be mutually beneficial to the hospital, the LME and the client. For instance, the hospital has the capacity to provide a more thorough and timely assessment of the client's physical and mental state and to provide 24-hour stabilization services to a broad spectrum of clients. The existence of a formal relationship provides the hospital with a level of certainty regarding the disposition of psychiatric, substance abuse and developmentally disabled clients who present at the hospital's emergency department. In addition to LME/hospital partnership being clinically efficacious, such arrangements also represent a more efficient and effective use of financial resources. Medicaid covers the cost of inpatient care for those clients who are Medicaid eligible. Medicaid, on the other hand, only covers the cost of treatment in crisis stabilization units, leaving the cost of room and board for all clients to be covered entirely with state and local appropriations.

An area program/LME should only consider the development of a crisis stabilization unit in cases where the LME and local hospital(s) are unable to agree to enter into a contractual relationship to provide emergency services or inpatient services.

APPENDIX E. NORTH CAROLINA HOSPITALS AND LOCAL MANAGEMENT ENTITIES COLLABORATION PROTOCOLS[12]

Background

Local hospitals play a unique role in assisting area authorities/county programs, hereafter known as Local Management Entities (LMEs), to carry out their mission. To appreciate their importance, one only needs to consider the fact that the local hospital emergency room is, generally, the place where, by design or default, people in psychiatric crisis present. In view of this, collaboration between the local hospital(s) and the LME is critical to the success of mental health reform and good client care. As a means of facilitating communication and collaboration, a group of thirteen individuals representing local hospitals and LMEs met for the purpose of establishing a protocol to guide local discussions on key issues related to mental health reform and the general working relationship between local hospitals and LMEs.

Although mental health reform has provided the impetus for the development of this document, many of the issues addressed in the protocol are longstanding and predate mental health reform. However, the advent of reform creates a more compelling need to resolve these issues. It is imperative that the Division of Mental Health, Developmental Disabilities and Substance Services, local hospitals and LMEs establish mutual trust and working relationships that can be acknowledged when asking other key community stakeholders to help in resolving crucial systems issues.

Common Interests

Local hospitals and LMEs serve a public or quasi-public function, i.e., meeting the health/mental health needs of the residents of their respective communities. As such, the goodwill of the public is a commodity of significance. There is much that hospitals and LMEs can do jointly to benefit the people being served and enhance public goodwill. Among those things, the parties can work together to: increase customer satisfaction; insure staff and patient safety while improving access to emergency, inpatient and outpatient services; promote the efficient use and leverage of community resources; recruit and retain competent and satisfied professional staff; improve risk management strategies; and develop and/or expand business relationships. Developing trust and working to address these common interests requires a concerted and sustained effort.

The Process

The process and issues that follow are meant to guide and facilitate collaboration between LMEs and local hospitals.

The Invitation: Based upon a recognition of common interests, the parties at the local level must assume responsibility for creating opportunities for dialogue that will lead to the development of solutions to the issues. While change does not occur overnight, it can be effected over time through affirmation of common interests, surfacing local nuances to issues raised in this protocol, by encouraging learning and innovation, recognizing what is outside local control, and reaching

[12] Originally distributed on August 8, 2003 as a memorandum to Area Directors and hospital CEOs from the Division, the N.C. Hospital Association and the N.C. Council of Community Programs.

consensus on solutions. The LME is encouraged to initiate the invitation to start the collaboration process, but the local hospital may also do so, depending on the particular need within the community.

The Convener: There are a number of methods that might be utilized, but it often helps to assign liaisons from each party to be accountable for managing the process, including developing agenda, insuring that key stakeholders are invited as key issues involve them, providing background materials, recording decisions and communicating the results to all stakeholders.

The Agenda: A solid agenda for a first meeting would be to establish a common objective and then to examine the local status of the issues listed in this document as well as identifying other issues that are relevant to the specific locality. It usually works best to establish a standing meeting time and a core of participants that can attend consistently.

The Participants: The core group should include those representatives of the parties that are authorized to speak on their behalf. Unless this authority exists, additional meetings are needed and results are impeded. The core group should also include ultimate customers, the persons likely to be served. Sometimes people with special expertise in a given issue are needed though not necessarily as regular participants. Core group participants could be chosen from among the following:

- ER managers
- Assessors
- LME triage
- Triage at Hospital
- Physicians
- LME Care Coordinators
- LME Utilization Manager
- LME Medical Director
- Consumer Representative of CFAC

The Issues: What follows is a summary of issues in three distinct categories that LMEs and Hospitals can use to initiate dialogue: Awareness, Access/EMTALA, and Inpatient Care/Follow-up. In no way is it implied that these issues exist in each locale. Also, it is understood that these are general issues identified by consensus as being of concern in many areas of the State. This protocol is not dictating a solution to these issues, but rather is requesting local dialogue and consensus on resolution of those issues specific to the local area.

Awareness

- There are varying levels of understanding about mental health reform

- Information and education regarding the State Plan is not always provided to the stakeholders using language that is easily understood

- The DMHDDSAS has a responsibility to be a part of the discussion

- State Hospitals need to be at the table and all local hospitals within the LME's geographic area should be included in the process

- Issues should be explored and discussed from a variety of perspectives

- Generally, there is insufficient understanding of the regulatory environments within which hospitals and LMEs must operate

- Constant attention should be given to identifying and removing roadblocks to collaboration at the local level and referring statewide barriers to the Task Force that has been established by the Division, the NC Hospital Association and the NC Council

- Line staff of both the hospital and LME must be apprised of the cooperative efforts that are being undertaken by the two parties.

The Participants: In addition to the core group, representatives of the following interests should be involved in helping to develop solutions to some of the awareness issues:

- Division of MHDDSAS

- LME Administration

- Hospital Administration

- ER Physicians

- Law Enforcement

- Consumers

- CFAC

- County Administrators

- Private Providers

- Primary Care Physicians & Pediatricians

- Other related Stakeholders represented on local Collaboratives such as DSS

Access/EMTALA

- ERs, generally, do not have the capacity to respond in a timely manner when multiple persons present at the ER in need of a mental health evaluation

- People needing a mental health evaluation are presenting at ERs in increasing numbers
- Hospitals bear a specific risk under EMTALA that is not shared by other organizations in the community
- Streamlining of the State Hospital referral process needs to occur*
- There is a need for timely identification of non-state hospital inpatient resources, possibly through the development of a statewide bed availability system
- Community development of alternatives to inpatient care is needed
- Credentialing & privileging of LME staff by local hospitals
- Transportation is an issue that keeps people in ERs and inpatient units longer than necessary
- Some local hospitals won't take an individual without a transportation plan which can hold up admissions
- There needs to be consistency among State Hospitals regarding requirements for clearance for admission*
- Access to consumer crisis plans and current medications would help ERs making dispositions
- A local diversion process for persons with a co-morbid developmental disability is needed*
- The parties need to feel comfortable with the level of risk involved in a disposition decision and the safety of the setting a person is discharged to
- ERs are burdened due to the time required to stabilize intoxicated people prior to admission
- Law enforcement has resource contingencies that may prevent staying with people in the ER creating safety issues

  *These issues have statewide implications and will also be addressed by the Division/Hospital Association/NC Council Task Force.

The Participants: In addition to the core group, representatives of the following interests should be involved in helping to develop solutions to specific aspects of the Access/EMTALA issues:

- ER managers
- Assessors
- LME triage

- Triage at Hospital
- Physicians
- LME Care Coordinators
- LME Utilization Manager
- LME Medical Director
- Consumers
- CFAC
- Division and State Hospitals
- Planner from LME
- Crisis Response Staff/Providers
- Law enforcement local and county
- Providers
- Magistrate
- DMA (resources)

Inpatient Care / Follow up

- Agreed upon admission criteria must address safety-staffing issues
- Transition and coordination of care issues needs to be clear and acceptable across all providers
- Medications needed after discharge must be available
- Lack of housing at discharge can create unnecessary extended lengths of stay
- Some local hospitals do not take Involuntary Commitments
- A lack of care coordination pre admission and post discharge causes recidivism and increased risk
- A general lack of access to inpatient beds is due, in part, to a lack of attending physician and other issues
- There is a lack of medical-psychiatric beds
- Inappropriate referrals come from the criminal justice system

- Reimbursement rates for inpatient care need to be examined
- Discharge summaries are requested before transfer and cannot be completed within 24 hours
- The Hospital as provider/LME relationship needs to be strengthened

The Participants: In addition to the core group, representatives of the following interests should be involved in the development of solutions to specific aspects of the inpatient care issue:

Hospital and LME CEOs

- ER managers
- Physicians
- LME Care Coordinators
- LME Utilization Manager
- LME Medical Director
- Hospital social work staff
- Consumers
- CFAC Community
- EMS
- DSS
- IP Managers of Local Hospitals
- Law Enforcement
- Division and State Hospital Administration

Barrier Busters: Division, Hospital Association, NC Council Task Force

The Division, the Hospital Association and the Council of Community Programs established a task force that began meeting in November 2002. The Task force is charged, among other things, to facilitate collaboration at the state level and to address issues that have statewide implications. Local collaborative work teams may submit issues of a statewide nature to the Task Force. The deliberations of the Task Force will be published on the DMHDDSAS web site.

Participants - North Carolina Hospitals and LMEs Collaboration Protocols

Mary Hill	Associate Vice Pres., Duke Univ. Health System
Karen Salacki	Area Director, Edgecombe-Nash Area Program
Jo Haubenreiser	Vice President, Novant Health System
William Nolan	Vice President, Novant Health System
Ron Morton	Area Director, CenterPoint Area Program
Carol D. Clayton	Executive Dir., NC Council of Community Programs
Janet Nottingham	Wilson Medical Center
Sam Pittman	Manager of Triage, Coastal Plain Hospital/Nash Health System
Mike Vicario	Vice President, Regulatory Affairs, NC Hospital Association
Tom McDevitt	Area Director, Smoky Mountain Area Program
Doug Trantham	Smoky Mountain Area Program
Ellen Holliman	Area Director, Durham Area Program
Don Willis	Chief, Administrative Support DMH/DD/SAS
Chris Thompson	Consultant